STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175452	A. Building B. Wing	03/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Gardens	1600 S Woodlawn Blvd Wichita, KS 67218

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility had a census of 79 residents, with three residents selected for sample. Based on observation and interview, the facility failed to provide one of three residents with a clean, comfortable, and homelike environment within the residents' room. (Resident (R) 1) Findings included: - Resident (R) 1's clinical record included a 01/20/20 Quarterly Minimum Data Set (MDS) which identified him with total dependence on staff for transfers and an inability to walk. R1 used a wheelchair to move about the facility. During an observation on 03/02/20 at 09:00 AM, R1 lay in his bed sleeping. A blue mattress lay on the floor next to the bed. The top surface of the mattress was heavily soiled with an unknown dried white material, lint and debris, and what appeared to be be long, dark human hairs. The wall surface at the head of the bead was deeply gouged in a somewhat circular area, the approximate size of a cantaloupe. The wall directly next to the bed contained deep linear gouges and exposed sheet rock. Both doors to the built in closet stood wide open and all of the cabinet doors stood open as well. Resident care items and personal belongings appeared to be tossed onto every available surface near the closet as well as on an overbed table. The adjacent bathroom contained a handsink which had deeply cracked/separated caulking the entire length of the sink. Vinyl base coving was pulled loose from the wall in several locations within the bathroom. The floor of the bathroom appeared dull, stained and unclean. A folding metal chair sat in the space between the toilet and the wall. Surfaces of the chair were rusted. A urinal hung from a grab bar located on the wall near the toilet, and R1's denture cup sat on the grab bar directly next to the urinal. During an interview on 03/02/20 at 12:19 PM, Maintenance Staff U reported the facility preventative maintenance plan did not include resident rooms, and he lacked a system that ensured periodic evaluation of maintenance needs within resident rooms. According to Maintenance Staff U, he depended on nursing staff or other staff to advise him of needed repairs, and then he responded to those requests. When asked about the condition of the walls within R1's room, Maintenance Staff U reported he does not repaint any surfaces because some residents complain about the smell of the paint. According to Staff U, he can patch holes in the wall but doesn't paint due to the smell. During an interview on 03/02/20 at 02:00 PM, Administrative Nurse D reported R1 lacked the ability to open closet doors/cabinet doors and move items onto all available surfaces. Administrative Nurse D reported she expected staff to make the rooms look nice for residents. Nurse D also reported staff should not store a denture cup next to a urinal in the bathroom. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175452	A. Building B. Wing	03/02/2020

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Preventative Maintenance of Resident Rooms policy included, All resident rooms shall be maintained in a safe and functional manner so as to assure the safety of residents, visitors and staff. Rooms shall be in compliance with any and all government regulations for safety. Any issues related to damaged furniture or fixtures or plant shall be reported to the Maintenance Director for repair. The facility failed to provide R1 with a clean, comfortable, and homelike environment within his room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 79 residents, with three residents selected for sample. Two sampled residents developed pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and friction.) after admission to the facility. Based on observation, interview and record review, the facility failed to provide two of two residents with the necessary care and services (consistent, timely assessment of skin in an attempt to identify early onset of skin issues; thorough and timely assessment of pressure ulcers, including staging and measurements) to prevent pressure ulcers and promote healing of existing pressure ulcers. Staff failed to complete weekly skin assessments for Resident (R) 1 for extended periods of time. R1 developed a pressure ulcer to the coccyx. Then, after development of a pressure ulcer, staff failed to complete thorough and timely assessment of the pressure ulcer, including staging and wound measurements. As of 03/02/20, R1 had a Stage 4 facility acquired pressure ulcer on the coccyx (a deep, full thickness wound with extensive destruction and damage to muscle/bone/supporting structures). Additionally, the facility admitted R2 on 01/14/20 for skilled nursing services. At the time of admission, R2 had a non-pressure wound to his left leg. The facility failed to consistently complete weekly skin assessments in an attempt to identify early onset of skin issues. R2 developed two facility acquired pressure ulcers in February 2020, one identified as a Stage 3 (a wound that extends through the upper layer of skin into the second layer of skin) and the other open but not currently staged. Findings included: - Resident (R) 1's clinical record included a comprehensive Medical diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . The 01/20/20 Quarterly Minimum Data Set (MDS) identified R1 with no cognitive impairment (Brief Interview for Mental Status score of 15), the need for extensive assistance of 1 staff for bed mobility, total dependence on two staff for transfers, and an inability to ambulate. R1 experienced functional limitations in range of motion on both lower extremities and used a wheelchair for mobility. R1 experienced frequent urinary incontinence and total bowel incontinence. According to the assessment, R1 had a current unstageable pressure ulcer which included slough (dead tissue, usually cream or yellow in color) and eschar (dead tissue). The unstageable wound was not present on admission to the facility. The 07/07/18 Care Plan noted R1's diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . The care plan also identified R1's risk for skin breakdown and history of amputations and ulcers. According to the care plan, staff should maintain R1 in the wheelchair for two hours or less and then lay him down to relieve pressure to the coccyx. The care plan directed staff to re-approach R1 when he refused wound care, and to complete skin assessments by licensed staff per scheduled protocol. Care Plan interventions included use of a full mechanical lift and two staff for transfers and assistance of one to two staff for repositioning. The Care Plan noted R1's refusal of care. The care plan lacked resident specific information related to the presence of a current pressure ulcer, the stage of the pressure ulcer, and treatment for [MEDICAL RECORD OR PHYSICIAN ORDER] (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Braden Skin Assessments (an assessment tool used to identify the risk of skin breakdown) identified R1 as moderate risk on 09/19/19 and high risk on 02/20/20. Documentation on the Weekly Skin Observation Tools revealed staff failed to complete any weekly skin checks in the six month time period from 06/24/19 - 01/09/20. Additional documentation included: 1) 01/09/20: The documentation lacked notation of any open wounds and included, No new skin issues. The clinical record lacked evidence of completion of additional weekly skin assessments until 01/23/20, a time period of 14 days. 2) 01/23/20: Described the presence of a 4 centimeter (cm) by 4 cm pressure wound to the sacrum (large triangular bone between the two hip bones) with minimum drainage and an odor. The note lacked a measurement of the depth of the wound and the stage. 3) 01/30/20: Described a right buttock pressure wound which measured 3.5 cm by 3.5 cm with a depth of 1.6 cm. Staff identified the pressure wound as a Stage 3 (a wound that extends through the upper layer of skin into the second layer of skin) with scant drainage. 4) 01/31/20: Described a Stage 3 pressure ulcer to the coccyx (small triangular bone at the base of the spine) with the same measurements as the previous day. 5) 02/03/20: Described a Stage 4 pressure ulcer (a deep, full thickness wound with extensive destruction and damage to muscle/bone/supporting structures) to the coccyx which measured 3 cm by 1.2 cm with a depth of 1.2 cm. The clinical record lacked evidence of completion of additional weekly skin assessments until 02/20/20, a time period of 17 days. 6) 02/20/20: Described a coccyx pressure ulcer which measured 3 cm by 1 cm with a depth of 0.1 cm Documentation from the contracted wound care company included: 1) 09/13/19: Described a resolved pressure ulcer to the coccyx and included, No open wounds present. 2) 02/03/20: Described recently resurfaced pressure injuries to the coccyx area which facility staff reported presented on 12/20/19. The note described the wound as full thickness (Stage 4) which measured 3 cm by 1. 2 cm with a depth of 1.2 cm., with joint and necrotic bone exposed. The note also described tunneling (progression of the wound via a channel into adjacent muscle/soft tissue) of the wound for a length of 1.6 cm with a large amount of serosanguinous (semi-thick reddish drainage) drainage with a mild odor. 3) 02/24/20: Described the coccyx pressure ulcer as full thickness (Stage 4) with worsening measurements of 3 cm by 2 cm with a depth of 1.5 cm. tunneling which measured 6 cm. Wound Weekly Observation Tools included the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1) 09/10/19: Described an improving coccyx wound. The documentation lacked measurements of the wound and/or staging information. The clinical record lacked evidence of completion of additional Wound Weekly Observation Tools until 02/25/20, a time period of more than five months. 2) 02/25/20: Described a Stage 3 worsening pressure ulcer which measured 3 cm by 2 cm with a depth of 1. 5 cm and tunneling. Progress Notes described R1's transfer and admission to an area hospital on 02/26/20 for an issue unrelated to the pressure ulcer. A progress note written on 02/27/20 at 05:33 PM described R1's readmission to the facility. The 02/27/20 note mentioned the presence of a dressing on R1's coccyx but lacked a description of the wound. As of 03/02/20, documentation in the clinical record from the time of R1's readmission on 02/27/20 - 03/02/20, a time period of four days, lacked evidence of assessment of the pressure ulcer on the coccyx. During an observation on 03/02/20 at 10:45AM, Licensed Nurse (LN) G and Consultant Mid-Level Practitioner GG prepared to examine R1's coccyx pressure ulcer while he lay on his side in bed. LN G removed a heavily saturated dressing from the coccyx. Consultant GG then measured the wound, including depth, and noted the presence of tunneling at various locations. Consultant GG described the pressure ulcer as Stage 4 with tunneling and the beginning of undermining (erosion of tissue around the wound edges). During an interview on 02/27/20 at 10:00 AM, Administrative Nurse E reported R1 developed a facility acquired pressure ulcer which advanced to Stage 3. During an interview on 03/02/20 at 08:30 AM, Administrative Nurse D verbalized knowledge licensed nurses failed to complete weekly skin assessments as scheduled. Administrative Nurse D also verbalized knowledge licensed nurses failed to thoroughly document assessments, including wound assessments such as R1's. On 03/02/20 at 12:20 PM, Administrative Nurse D reported she just found out the electronic health record system failed to notify licensed nurses of when weekly skin assessments came due, and that explained in part why the nurses failed to complete the assessments. On 03/02/20 at 2:30 PM, Administrative Nurse D reported R1 frequently spit at staff and/or attempted to hit them, In spite of those behaviors, Administrative Nurse D reported staff still needed to find a way to provide R1 with the care he needed rather than avoiding him. The facility's July, 2017, Prevention of Pressure Ulcers/Injuries policy directed staff to complete a comprehensive skin assessment upon admission. The policy also directed staff to inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living. According to the policy, the purpose of completing the daily inspection was, in part, to inspect pressure points and identify any signs of developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility failed to complete routine weekly skin assessments for Resident (R) 1 for extended periods of time. R1 developed a pressure ulcer to the coccyx. Then, after development of a pressure ulcer, staff failed to complete thorough and timely assessment of the pressure ulcer, including staging and wound measurements. As of 03/02/20, R1 had a Stage 4 facility acquired pressure ulcer on the coccyx (a deep, full thickness wound with extensive destruction and damage to muscle/bone/supporting structures). - Resident (R) 2's clinical record included a comprehensive Medical diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . The 01/21/20 Admission Minimum Data Set (MDS) identified R2 with the need for extensive assistance of two staff for bed mobility, total dependence on two staff for transfers, and an inability to ambulate. R2 experienced functional limitations in range of motion to all four extremities. The assessment noted the presence of an unhealed Stage 2 pressure ulcer (a break in intact skin which exposes underlying tissue), a risk for development of pressure ulcers, and application of nonsurgical dressings to areas other than the feet. The 01/24/20 Care Plan noted R2's risk for pressure ulcer development due to a past history of ulcers as well as immobility. The Care Plan directed staff to assess, record, and monitor wound healing. Measure length, width and depth when possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician . The care plan lacked specific interventions related to pressure reduction in an attempt to prevent pressure ulcer development. The 01/14/20 Braden Skin Assessment, an assessment used to measure risk for pressure ulcer development, identified R2 as moderate risk. A subsequent 01/16/20 assessment identified R2 as no risk. physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER] . Review of Weekly Skin Observation Tools revealed the following: 1) 01/14/20 (date of admission): Identified the presence of skin discoloration to toes on the left foot and a purplish scab on the right great toe. Staff failed to complete another weekly skin assessment until 01/24/20, 10 days later. 2) 01/24/20: Identified the presence of an inner left ankle laceration (wound to the skin) of unknown origin. The inner ankle wound measured 5.0 centimeters (cm) by 2.0 cm with a depth of 0.1 cm. The documentation lacked staging of the wound. The documentation also failed to indicate if the ankle wound was a pressure wound. 3) 01/27/20: Identified the presence of a left lower extremity pressure wound which measured 2.5 cm by 3.0 cm with a depth of 0.1 cm. The documentation lacked a description of the specific location on the left lower extremity and also lacked staging of the wound. 4) 02/03/20: Referred to a Stage 3 pressure ulcer to the left lower extremity which measured 3 cm by 2 cm with a depth of 0.1 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The clinical record lacked evidence of completion of additional weekly skin assessments until 02/19/20, 16 days later. 5) 02/17/20: Documented the presence of a worsening medial [middle] left lower extremity vascular wound which measured 3.5 cm by 1 cm with a depth of 0.1 cm. The assessment identified the wound as deteriorating and noted management of the wound by a contracted wound care company. According to the assessment, R2 had no wounds or skin impairment issues other than the left extremity vascular wound. The clinical record lacked evidence of completion of additional weekly skin assessments in the 14 day time period from 02/17/20 - 03/02/20. Documentation by the contracted wound care company from 01/27/20 - 02/17/20 identified R2 with one wound, a chronic full thickness wound - non-pressure to the left lower medial extremity. The contracted wound care company documentation lacked mention of any other areas of skin breakdown. Skilled Nursing Charting for the time period from admission on 01/14/20 - 02/26/20 revealed a total of 67 entries which prompted staff to assess the resident in a variety of different areas, including Wound/Skin. Of those 67 entries, 47 indicated R2 had no treatable wounds even though he had a wound on the left lower extremity which required daily dressing changes. An additional five Skilled Nursing notes lacked any documentation in the Wound/Skin section and that section remained entirely blank. Progress Notes included: 1) 02/28/20 at 02:46 PM: Described a new wound on the left heel which measured 3 inches by 2 inches. The documentation lacked information related to staging. 2) 02/29/20 at 10:07 PM: Described a Stage 3 pressure area near the coccyx. The documentation lacked measurements or other assessment information. Review of the electronic health record lacked any other documentation related to the two new facility acquired pressure ulcers from the time staff identified them on 02/28/20 (left heel) and 02/29/20 (area near coccyx) until 03/02/20. During observations on 02/27/20 at 01:00 PM and 03:10 PM, R2 lay supine (on his back) in bed with both feet sticking out from under the bed linens. The feet lacked pressure reduction devices (soft boots etc) or a pillow beneath the feet to float the heels. During the observations, R2 had the ability to verbalize his needs. He lacked the ability to move his lower extremities. Both feet were hyperextended at the ankles which caused the feet to point downward. Observation of R2's side of the room revealed no pressure reduction devices for his feet, such as soft boots, within view. When asked if staff ever attempted to place soft boots or other pressure reduction devices on his feet, R2 replied, Nope. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 03/02/20 at 10:50 AM, Licensed Nurse (LN) G and Consultant Mid-level Practitioner GG examined R2's wounds. Consultant GG initially reported R2 had only one non pressure wound to the left lower leg. Then, upon LN G's report of new wounds, stated, Well, he only had one when I saw him last time. I guess the others are new. Upon examination, R2 had a large, circular wound partially covered with eschar (dead tissue) to the inner left heel. Consultant GG confirmed the presence of eschar on part of the wound and identified the wound as a Stage 3 pressure ulcer. LN G also reported recent development of a new pressure ulcer on the coccyx which staff were unable to measure or stage due to R2's refusals. According to LN G, staff told her the coccyx pressure ulcer was also a Stage 3. At the time of the observation, R2 again refused to allow LN G and Consultant GG to observe/examine the newly developed pressure ulcer on the coccyx. During an interview on 03/02/20 at 11:00 AM, LN G confirmed R2 developed two new pressure ulcers within the last week, and at least one of those pressure ulcers was a Stage 3. According to LN G, R2 frequently refused wound treatments, repositioning and use of pressure reduction devices such as heel protectors or pillows to float the heels but she lacked awareness if anyone documented those refusals. During an interview on 03/02/20 at 08:30 AM, Administrative Nurse D verbalized knowledge licensed nurses failed to complete weekly skin assessments as scheduled. On 03/02/20 at 12:20 PM, Administrative Nurse D reported she just found out the electronic health record system failed to notify licensed nurses of when weekly skin assessments came due, and that explained in part why the nurses failed to complete the assessments. The facility's February 2014 Pressure Ulcer/Injury Risk Assessment policy directed staff to complete a risk assessment weekly for the first four weeks after admission, and to complete a comprehensive skin assessment with every risk assessment. The facility's July 2017 Prevention of Pressure Ulcers/Injuries policy directed staff to complete a comprehensive skin assessment upon admission. The policy also directed staff to inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living. According to the policy, the purpose of completing the daily inspection was, in part, to inspect pressure points and identify any signs of developing pressure injuries. The facility admitted R2 on 01/14/20 for skilled nursing services. At the time of admission, R2 had a non-pressure wound to his left leg. The facility failed to consistently complete weekly skin assessments in an attempt to identify early onset of skin issues. R2 developed two facility acquired pressure ulcers in February 2020, one identified as a left heel Stage 3 at the time of discovery and the other wound near the coccyx open but not currently staged.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. The facility had a census of 79 residents. The facility employed 11 licensed nurses. Based on interview and record review, the facility failed to ensure 8 of 11 licensed nurses had the specific competencies and skill sets related to nursing assessments to care for residents. Findings included: - Record review for sampled residents (R) 1, R2, and R3 revealed numerous incidents in which licensed nurses failed to complete weekly skin assessments and wound assessments, as well as failure to accurately and thoroughly document the resident medical conditions. The facility provided a list of eleven licensed nurses employed by the facility. In response to a request for evidence of completion of competencies related to nursing assessment and/or documentation, Administrative Nurse D provided evidence of competency testing for three of 11 nurses. During an interview on 03/02/20 at 08:30 AM, Administrative Nurse D verbalized knowledge licensed nurses failed to complete weekly skin assessments as scheduled. Administrative Nurse D also verbalized knowledge licensed nurses failed to thoroughly document assessments, including wound assessments. Nurse D reported she planned to have a local college/technical school provide training on nursing assessments to licensed nurses. The facility failed to provide a policy related to competency training of licensed nurses. The facility failed to ensure 8 of 11 licensed nurses had the specific competencies and skill sets related to nursing assessments to care for residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. The facility had a census of 79 residents, with three residents selected for sample. Based on interview and record review, the facility failed to obtain and administer a medicated cream ordered by the physician for one of three sampled residents. (Resident (R) 3) Findings included: - R3's clinical record included an 01/03/20 Physician's Order for Urea 40% cream to both feet daily for dry and fissued [cracked/split] skin. The clinical record lacked evidence the facility processed the medication order and then applied it twice daily as ordered by the podiatrist. During an interview on 03/02/20 at 02:30 PM, Administrative Nurse D denied knowledge of R3's order for Urea 40% cream but said she would check on it. Survey staff made multiple requests (03/02/20 at 02:30 PM with Administrative Nurse D, 03/04/20 and 03/05/20 via email to Administrative Staff A, Administrative Nurse D and Administrative Nurse E) for documentation of application of R3's Urea 40% cream as ordered by the physician on 01/03/20. The facility failed to provide the requested documentation. The facility failed to provide a policy related to administration of medications as ordered by the physician. The facility failed to obtain and administer a medicated cream ordered by the physician for R3.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. The facility had a census of 79 residents, with three residents selected for sample. Based on observation, interview, and record review, the facility failed to implement infection control measures to prevent the spread of infection when a licensed nurse and contracted mid-level practitioner failed to wash their hands after examination and measurement of Resident (R) 1's pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Findings included: - During an observation on 03/02/20 at 10:45 AM, Licensed Nurse (LN) G and Consultant Mid-level Practitioner GG prepared to examine R1's coccyx (small triangular bone at the base of the spine) pressure ulcer. With gloved hands, LN G removed a dressing saturated with drainage from the Stage 4 pressure ulcer (a deep, full thickness wound with extensive destruction and damage to muscle/bone/supporting structures). Consultant GG then used gloved hands to measure the length and width of the wound. She then inserted a probe into the wound to measure the depth. Upon completion of the examination and measurements, LN G and Consultant GG both removed their gloves and left R1's room without washing their hands. Upon exiting the room, LN G placed her hands on the treatment cart and pushed it down the hallway to the nurse's station. Consultant GG followed LN G to the nurse's station and both washed their hands at the sink at the nurses's station. During an interview on 03/02/20 at 01:00 PM, LN G reported she should have washed her hands in R1's room after glove removal and prior to exiting the room. During an interview on 03/02/20 at 02:00 PM, Administrative Nurse D reported staff should remove gloves and wash hands after providing care to residents, and staff should wash the hands prior to leaving the room. The facility's December 2007 Standard Precautions policy directed staff to .Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments . The facility failed to implement infection control measures to prevent the spread of infection when a licensed nurse and contracted mid-level practitioner failed to wash their hands after examination and measurement of R1's pressure ulcer.